

SECTION 4

MEDICARE CROSSOVER CLAIMS

Medicare/Medicaid (crossover) claims that do not cross automatically from Medicare to Medicaid, must now be filed through the Medicaid billing Web site at www.emomed.com or through the 837 electronic claims transaction. This requirement became effective July 1, 2005. Before filing an electronic crossover claim, please wait sixty (60) days from the date of your Medicare payment to avoid possible duplicate payments from Medicaid.

The major reason that claims do not cross over electronically from Medicare to Medicaid is because Medicaid enrolled providers have not provided Medicaid with their Medicare provider number or have provided an invalid or inactive Medicare provider number. If the provider is enrolled with Medicare as a group/clinic, then the provider must also enroll with Medicaid as a clinic. Both the group/clinic Medicare number and each individual practitioner's Medicare number must be on file with Medicaid. If the provider has more than one number with Medicare and Medicaid, be sure to provide the proper Medicare number for each specific Medicaid provider number or the claims may not cross to Medicaid electronically.

If the provider has any doubt as to what Medicare number(s) is (are) on file for the provider, contact the Provider Enrollment Unit by e-mail at providerenrollment@dss.mo.gov. If you have not submitted your provider number to Medicaid, you can fax a copy of the Medicare letter showing the Medicare provider name and Medicare number assigned along with a cover letter explaining why the information is being submitted to the enrollment unit. The unit's fax number is 573/526-2054.

Following are tips to assist you in successfully filing a claim at the Medicaid billing Web site:

- At the Medicaid billing Web site at www.emomed.com, choose the same crossover claim form that you completed to bill Medicare. For professional crossover claims, select "Medicare CMS 1500 Part B Crossover." For FQHC claims, select either "Medicare CMS 1500 Part B Crossover" or "Medicare UB-92 Part B of A Crossover" whichever is appropriate. For dialysis center claims, select "Medicare UB-92 Part B of A Crossover." Be sure you select the correct provider number from the drop down box in the upper right hand corner of the first claims screen. If you filed to Medicare under a clinic number, then you should file to Medicaid under a clinic number. If you filed to Medicare under an individual provider number, you should file to Medicaid under an individual provider number.
- There are HELP screens at the bottom of each screen page to provide instructions for completing the crossover claim screens, the "Other Payer" header

and the "Other Payer" detail screens. Print each HELP screen in its entirety for reference when completing claims on the Internet.

- Enter the information in the fields on the screen exactly as you did on your Medicare billing except that you should enter the patient's name as it appears on the Medicaid card and **not** the name that is shown on the Medicare remittance advice.
- There must be an "Other Payer" header screen completed for every crossover claim type. This provides information that pertains to the whole claim.
- Part B and Part B of A claims need the "Other Payer" header form completed without group code, reason code and adjustment amount information. Completion of an "Other Payer" detail screen form is required for each claim detail line.
- The five (5) codes that can be entered in the "Group Code" field on the "Other Payer" Header and Detail screen forms are in a drop down box and you should choose the appropriate code. For example, the "PR" code (patient responsibility) is understood to be the code assigned for deductible and/or coinsurance amounts shown on your Medicare EOMB.
- The codes to enter in the "Reason Code" field on the "Other Payer" Header and Detail screen forms are found on your Medicare EOMB. If not listed there, you must choose the most appropriate code from the list of "Claim Adjustment Reason Codes" which can be found in the HIPAA Related Code List under the Quick Links at <http://www.dss.mo.gov/dms/providers.htm>. For example, the code shown on the "Claim Adjustment Reason Codes" list for "deductible amount" is 1 and for "coinsurance amount" is 2. Therefore, you would enter a "Reason Code" of "001" for deductible amounts due and a "Reason Code" of "002" for coinsurance amounts due.
- The "Adjust Amount" should reflect any amount not paid by Medicare including deductible, coinsurance, and any non-allowed amounts.
- If there is a commercial insurance payment or denial to report on the crossover claim, you must complete an additional "Other Payer" Header form. You must also complete an additional "Other Payer" Detail form(s) if the commercial carrier provided detail line information for line payments and denials.

Samples of Part B (professional) (including one with commercial insurance in addition to Medicare and Medicaid), Part B of A (FQHC) and Part B of A (dialysis) claims are displayed on the following pages.

SAMPLE MEDICARE REMITTANCE PART B - CMS - 1500 (NO TPL)

CENTRAL CLINIC
P.O. BOX 25X
JEFFERSON, MO 65107

MEDICARE
REMITTANCE
NOTICE

PROVIDER: F00000XA
PAGE #: 1 OF 1
DATE: 02/01/2006
CHECK/EFT #: 000257X
STATEMENT #: 09050007XY

<u>PERF</u>	<u>PROV.</u>	<u>SERV DATE</u>	<u>POS NOS</u>	<u>PROC</u>	<u>MODS</u>	<u>BILLED</u>	<u>ALLOWED</u>	<u>DEDUCT</u>	<u>COINS</u>	<u>GRP/RC-AMT</u>	<u>PROV PD</u>
NAME: SHRIEK, WILL HIC: 4900000000A ACNT: 100WS ICN 06027000000000											
F000000A		0105 010506 21	1	99231		51.00	32.35	0.00	6.47	CO-42	18.65 25.88
PT RESP		6.47		CLAIM TOTALS		51.00	32.35	0.00	6.47		18.65 25.88
ADJ TO TOTALS: PREV PD 0.00						INTEREST:	0.00	LATE FILING CHARGE 0.00			NET 25.88

Using this example of a Medicare EOMB, the following pages will guide you step-by-step through the process to file your Crossover Claim through the Medicaid billing web site at www.emomed.com to collect the co-insurance amount.



State of Missouri Medicaid



Medicare CMS 1500 Part B Crossover

If you are not , please logout

Logout

User:

Provider:

500000000 SAMPLE NUMBER

Claim Frequency Type Code*		Provider Medicare number			
1-Original		F00000XA			
Patient Name (Last Name, First Name)*		Patient Medicaid ID*			
Shriek Will		99999999			
Patient Medicare ID (HIC)*		Patient Account No.			
490000000A		100ws			
Hospitalization Dates (mm/dd/yy)*		Diagnosis Codes* (Do not include the decimal)			
From Date 01 / 05 / 06		1. 46619 2. 3. 4. 5.			
Thru Date 01 / 05 / 06					
Resubmission Ref. No.					
Line No.	From Date of Service (mm/dd/yy)*	Diagnosis Code*	Paid Amount \$*	Detail Line Attachments	
	Thru Date of Service (mm/dd/yy)*	Days/Units Billed*			
	Place of Service*	Billed Charges \$*	Medicaid Performing Provider ID*		
	Procedure Code* and Modifiers				
1.	01 / 05 / 06	0	0.00	[Other Payers]	
	01 / 05 / 06	0.00			

ADD DETAIL LINES

Claim Attachment Actions:

[\[Add Header Other Payers\]](#) [\[View All Other Payers\]](#)

Continue...

Reset

[\[Home\]](#) [\[Help\]](#)

- At the Medicaid billing Web site, click on “Medicare CMS 1500 Part B Crossover”. That will bring you to the screen above.
- Enter all the Medicaid header information. Refer to the Medicare EOMB on the previous page as well as the patient’s medical record. Complete the fields as shown above. Then click on “Add Header Other Payers” link at the bottom of the page to enter the header other payer information.
- Note-if the service was not provided in the hospital, enter all zeros in the “Hospitalization Dates” fields.



State of Missouri Medicaid



Other Payer Header Information

Enter Other Payer(s) Header Information for Medicare CMS 1500 Part B Crossover claim.

Fields marked * must be filled in.

Other Payer #1					
Filing Indicator* MB-Medicare		Other Payer Name* Medicare Part B			
Paid Amount \$ 25.88		Paid Date (mm/dd/yy)* 02 / 01 / 06		Medicare Claim No. 06027000000000	
Header Allowed Amount \$ * 32.35			Total Denied Amount \$ 0.00		
Group Codes, Reason Codes & Adjustment Amounts					
Group Code	Reason Code	Adjust Amount \$	Group Code	Reason Code	Adjust Amount \$
Add Reason Codes					
Remark Codes					
Remove Payer #1					

Add Payer

Done

Cancel

[\[Help\]](#)

- Now you are on the "Other Payer Header" screen.
- Enter the information as shown. For Part B and Part B of A crossover claims, do not complete the Group Codes, Reason Codes and Adjustment Amounts information. You will be entering this information elsewhere.
- Click on "Done".



State of Missouri Medicaid



Medicare CMS 1500 Part B Crossover

If you are not , please logout

Logout

User:

Provider:

500000000 SAMPLE NUMBER

Claim Frequency Type Code*		Provider Medicare Number*		
1-Original		F00000XA		
Patient Name (Last Name, First Name)*		Patient Medicaid ID*		
Shriek Will		99999999		
Patient Medicare ID (HIC)*		Patient Account No.		
490000000A		100ws		
Hospitalization Dates (mm/dd/yy)*		Diagnosis Codes* (Do not include the decimal)		
From Date 01 / 05 / 06		1. 46619 2. 3. 4. 5.		
Thru Date 01 / 05 / 06				
Resubmission Ref. No.				
Line No.	From Date of Service (mm/dd/yy)*	Diagnosis Code*	Paid Amount \$*	Detail Line Attachments
	Thru Date of Service (mm/dd/yy)*	Days/Units Billed*		
	Place of Service*	Billed Charges \$*	Medicaid Performing Provider ID*	
	Procedure Code* and Modifiers			
1.	01 / 05 / 06 01 / 05 / 06 21-Inpatient 99231	1 1 51.00	25.88 200000000	[Other Payers]
ADD DETAIL LINES				

Claim Attachment Actions:

[\[Add Header Other Payers\]](#) [\[View All Other Payers\]](#)

Continue...

Reset

[\[Home\]](#) [\[Help\]](#)

- Now you are back on the original screen ready to add your detail information to the claim.
- Again, using the Medicare EOMB example from the previous page, enter the detail information as shown above.
- When done entering the information, click on "Other Payers" to add the Medicare detail information.



State of Missouri Medicaid



Other Payer Detail Information

Enter Other Payer(s) Detail Information for Medicare CMS 1500 Part B Crossover claim.

Fields marked * must be filled in.

Claim Detail Line #1

Other Payer #1

Paid Date (mm/dd/yy)*						02	/	01	/	06
Group Codes, Reason Codes & Adjustment Amounts										
Group Code		Reason Code	Adjust Amount \$	Group Code		Reason Code	Adjust Amount \$			
CO-Contractual Obligation		042	18.65	PR-Patient Responsibility		002	6.47			
								Add Reason Codes		
								Remove Payer #1		


Add Payer

Done


Cancel

[\[Help\]](#)

- Now you are on the "Other Payer Detail" screen.
- Enter the Medicare paid date information as well as the Group and Reason Codes and Adjustment Amounts. See the above sample. If the reason codes are not listed on your Medicare EOMB, choose the most appropriate code from the list of "Claim Adjustment Reason Codes" from the HIPAA Related Code List. For example, the code on the "Claim Adjustment Reason Code" list for deductible amount is 1 and for coinsurance amount is 2. Therefore, you would enter a Reason Code of 001 for deductible amounts and 002 for coinsurance amounts due.
- The "Adjust Amount" should reflect any amount not paid by Medicare including deductible, coinsurance and any non-allowed amounts.
- Click on "Done".



State of Missouri Medicaid



Medicare CMS 1500 Part B Crossover

If you are not , please logout Logout

User: Provider: 500000000 SAMPLE NUMBER

Claim Frequency Type Code*			Provider Medicare Number*		
1-Original			F00000XA		
Patient Name (Last Name, First Name)*			Patient Medicaid ID*		
Shriek Will			99999999		
Patient Medicare ID (HIC)*			Patient Account No.		
490000000A			100ws		
Hospitalization Dates (mm/dd/yy)*			Diagnosis Codes* (Do not include the decimal)		
From Date 01 / 05 / 06			1. 46619 2. 3. 4. 5. 		
Thru Date 01 / 05 / 06					
Resubmission Ref. No.					
					

Line No.	From Date of Service (mm/dd/yy)*		Diagnosis Code*	Paid Amount \$*	Detail Line Attachments
	Thru Date of Service (mm/dd/yy)*		Days/Units Billed*		
	Place of Service*		Billed Charges \$*	Medicaid Performing Provider ID*	
	Procedure Code* and Modifiers				
1.	01 / 05 / 06	01 / 05 / 06	1	25.88	[Other Payers]
	21-Inpatient		1	200000000	
	99231		51.00		

ADD DETAIL LINES

Claim Attachment Actions:
[\[Add Header\]](#) [\[Other Payers\]](#) [\[View All Other Payers\]](#)
Continue... Reset

[\[Home\]](#) [\[Help\]](#)

- This brings you back to the original screen. At this point, you are done entering the information. Click on “Continue”.
- This brings you to a screen asking you to verify the information entered. You can either edit the information or submit the claim.
- Click on “Submit”. After submitting your claim, you will be brought to a screen which states, “Thank you. Your claim has been received”. Click on the “Print” button at the bottom of the screen to print off and save for your records.
- To enter another claim, click on “Next”.

The end.

SAMPLE MEDICARE REMITTANCE

PART B - CMS - 1500 (With Commercial Insurance)

CENTRAL
CLINIC
P.O. BOX 25X
JEFFERSON, MO 65107

MEDICARE
REMITTANCE
NOTICE

PROVIDER: F00000XA
PAGE #: 1 OF 1
DATE: 02/01/06
CHECK/EFT #: 000257X
STATEMENT #: 09050007XY

PERF PROV.	SERV DATE	POS NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC- AMT	PROV PD
NAME: SHRIEK, WILL		HIC: 490000000A		ACNT: 100WS		ICN 0602700000000				
F000000A	0106 010506	1	99231		51.00	32.35	0.00	42	18.65	25.88
PT RESP	6.47		CLAIM TOTALS		51.00	32.35	0.00	6.47	18.65	25.88
	PREV PD						LATE FILING			NET
ADJ TO TOTALS:	0.00		INTEREST:		0.00		CHARGE		0.00	25.88

Using this example of a Medicare EOMB and the one on the next page for commercial insurance, the following pages will guide you step-by-step through the process to file a Medicare crossover with additional commercial insurance through the Medicaid billing Web site at www.emomed.com to collect the co-insurance amount

Please turn the page for the sample commercial EOMB.

MEDICARE PART B WITH TPL SAMPLE TPL EOB

ABC INS.

ABC SERVICE CENTER
P.O. BOX 1111
ANYWHERE, MO 64109

DATE: 02/16/06
GROUP #: 002
GROUP NAME: CPI
CHECK NUMBER: X27445
CHECK AMOUNT: \$5.18

CENTRAL CLINIC
P.O. BOX 25X
JEFFERSON CITY, MO 65107

PRODUCT	MEM ID	PATIENT NAME	PATIENT ACCOUNT	MEMBER NAME SHRIEK, WILL	CONTROL NUMBER	DATE RECEIVED	DATE RECEIVED	PROVIDER OF SERVICE			
IND	A X9974	SHRIEK, WILL	5205X		61725	02/13/2006	02/13/2006	CENTRAL CLINIC			
PATIENT NAME	DATES OF SERVICE	DESCRIPTION OF SERVICE	AMOUNT CHARGED	NOT COVERED	PROV ADJ DISCOUNT	AMOUNT ALLOWED	CO-INS PLAN COV 6.47 80%	PAID TO PROVIDER	RMK CD	PATIENT RESP.	
SHRIEK, WILL	01/05/06	99231	51.00			32.35		5.18	PR2	1.29	
		SUBTOTAL	51.00			32.35	6.47	5.18		1.29	
TOTAL PAID TO PROVIDER:								5.18			

This is a sample EOB for a commercial insurance that pays 80% of the patient's Medicare co-insurance.

Please turn the page to start the process for filing.



State of Missouri Medicaid



Medicare CMS 1500 Part B Crossover

If you are not , please logout

Logout

User:

Provider:

500000000 SAMPLE NUMBER

Claim Frequency Type Code*		Provider Medicare Number*		
1-Original		F00000XA		
Patient Name (Last Name, First Name)*		Patient Medicaid ID*		
Shriek Will		99999999		
Patient Medicare ID (HIC)*		Patient Account No.		
490000000A		100ws		
Hospitalization Dates (mm/dd/yy)*		Diagnosis Codes* (Do not include the decimal)		
From Date 01 / 05 / 06		1. 46619 2. 3. 4. 5.		
Thru Date 01 / 05 / 06				
Resubmission Ref. No.				
Line No.	From Date of Service (mm/dd/yy)* Thru Date of Service (mm/dd/yy)* Place of Service* Procedure Code* and Modifiers	Diagnosis Code* Days/Units Billed* Billed Charges \$*	Paid Amount \$* Medicaid Performing Provider ID*	Detail Line Attachments
1.	<div> <div> <div></div> <div></div> <div></div> </div> <div> <div></div> <div></div> <div></div> </div> <div> <div></div> <div></div> <div></div> </div> </div>	<div> <div></div> <div>0</div> <div>0.00</div> </div>	<div> <div>0.00</div> <div></div> </div>	[Other Payers]

ADD DETAIL LINES

Claim Attachment Actions:

[\[Add Header Other Payers\]](#) [\[View All Other Payers\]](#)

Continue...

Reset

[\[Home\]](#) [\[Help\]](#)

- At the Medicaid billing Web site, click on “Medicare CMS 1500 Part B Crossover”. That will bring you to the screen above.
- Complete all the Medicaid header information. Refer to the Medicare EOMB on the previous page as well as the patient’s medical record. Complete the fields as shown above then click on the “Add Header Other Payers” link at the bottom of the page to add the header other payer information.



State of Missouri Medicaid



Other Payer Header Information

Enter Other Payer(s) Header Information for Medicare CMS 1500 Part B Crossover claim.

Fields marked * must be filled in.

Other Payer #1					
Filing Indicator* <input type="text" value="MB-Medicare"/>		Other Payer Name* <input type="text" value="Medicare Part B"/>			
Paid Amount \$ <input type="text" value="25.88"/>		Paid Date (mm/dd/yy)* <input type="text" value="02 / 01 / 06"/>		Medicare Claim No. <input type="text" value="0602700000000"/>	
Header Allowed Amount \$ * <input type="text" value="32.35"/>		Total Denied Amount \$ <input type="text" value="0.00"/>			
Group Codes, Reason Codes & Adjustment Amounts					
Group Code	Reason Code	Adjust Amount \$	Group Code	Reason Code	Adjust Amount \$
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="button" value="Add Reason Codes"/>					
Remark Codes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>					
<input type="button" value="Remove Payer #1"/>					
Other Payer #2					
Filing Indicator* <input type="text" value="CI-Commercial Insurance Co"/>		Other Payer Name* <input type="text" value="ABC Insurance"/>			
Paid Amount \$ <input type="text" value="5.18"/>		Paid Date (mm/dd/yy)* <input type="text" value="02 / 16 / 06"/>		Medicare Claim No. <input type="text" value="61725"/>	
Header Allowed Amount \$ * <input type="text" value="51.00"/>		Total Denied Amount \$ <input type="text" value="0.00"/>			
Group Codes, Reason Codes & Adjustment Amounts					
Group Code	Reason Code	Adjust Amount \$	Group Code	Reason Code	Adjust Amount \$
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="button" value="Add Reason Codes"/>					
Remark Codes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>					
<input type="button" value="Remove Payer #2"/>					
<input type="button" value="Add Payer"/>					
<input type="button" value="Done"/> <input type="button" value="Cancel"/>					

[\[Help\]](#)

- Now you are on the “Other Payer Header” screen. Enter the information at the top as shown. For Part B and Part B of A crossover claims, do not complete the Group Codes, Reason Codes and Adjustment Amounts information. You will be entering this information elsewhere.
- Using the commercial insurance EOB, enter the appropriate information. The header allowed amount for this section is the amount you billed to Medicare, not the amount allowed by the commercial plan. If the commercial plan did not assign the claim a number, enter six (6) nines in the Medicare claim number field for payer #2.
- Click on “Done”.



State of Missouri Medicaid



Medicare CMS 1500 Part B Crossover

If you are not , please logout

Logout

User:

Provider:

500000000 SAMPLE NUMBER

Claim Frequency Type Code*		Provider Medicare Number*		
1-Original		F00000XA		
Patient Name (Last Name, First Name)*		Patient Medicaid ID*		
Shriek Will		99999999		
Patient Medicare ID (HIC)*		Patient Account No.		
490000000A		100ws		
Hospitalization Dates (mm/dd/yy)*		Diagnosis Codes* (Do not include the decimal)		
From Date 01 / 05 / 06		1. 46619 2. 3. 4. 5.		
Thru Date 01 / 05 / 06				
Resubmission Ref. No.				
Line No.	From Date of Service (mm/dd/yy)*	Diagnosis Code*	Paid Amount \$*	Detail Line Attachments
	Thru Date of Service (mm/dd/yy)*	Days/Units Billed*		
	Place of Service*	Billed Charges \$*	Medicaid Performing Provider ID*	
	Procedure Code* and Modifiers			
1.	01 / 05 / 06	1	25.88	[Other Payers]
	01 / 05 / 06	1	200000000	
	21-Inpatient	51.00		
	99231			

ADD DETAIL LINES

Claim Attachment Actions:

[\[Add Header Other Payers\]](#) [\[View All Other Payers\]](#)

Continue...

Reset

[\[Home\]](#) [\[Help\]](#)

- Now you are back on the original screen ready to add your detail information to the claim.
- Again, using the Medicare EOMB example from the previous page, enter the detail information as shown above.
- When done entering the information, click on "Other Payers" to add the Medicare and commercial insurance detail information.



State of Missouri Medicaid



Other Payer Detail Information

Enter Other Payer(s) Detail Information for Medicare CMS 1500 Part B Crossover claim.

Fields marked * must be filled in.

Claim Detail Line #1					
Other Payer #1					
Paid Date (mm/dd/yy)*		02 / 01 / 06			
Group Codes, Reason Codes & Adjustment Amounts					
Group Code	Reason Code	Adjust Amount \$	Group Code	Reason Code	Adjust Amount \$
CO-Contractual Obligation	042	18.65	PR-Patient Responsibility	002	6.47
Add Reason Codes					
Remove Payer #1					
Other Payer #2					
Paid Date (mm/dd/yy)*		02 / 16 / 06			
Group Codes, Reason Codes & Adjustment Amounts					
Group Code	Reason Code	Adjust Amount \$	Group Code	Reason Code	Adjust Amount \$
OA-Other Adjustments	023	25.88	CO-Contractual Obligation	042	18.65
PR-Patient Responsibility	002	1.29			
Add Reason Codes					
Remove Payer #2					
Add Payer					
Done Cancel					

[\[Help\]](#)

- Now you are on the “Other Payer Detail” screen. Complete the Medicare paid date information as well as the Group and Reason Codes and Adjustment Amounts. See above sample. If the reason codes are not listed on your Medicare EOMB, choose the most appropriate code from the list of “Claim Adjustment Reason Codes” from the HIPAA Related Code List. For example, the code on the “Claim Adjustment Reason Code” list for deductible amount is 1 and for coinsurance amount is 2. Therefore, you would enter a Reason Code of 001 for deductible amounts and 002 for coinsurance amounts due.
- The “Adjust Amount” should reflect any amount not paid by Medicare including deductible, coinsurance and any non-allowed amounts.
- Enter the same information for the commercial carrier. Your first entry should be “OA-Other Adjustment” 023. This is the amount Medicare has already reimbursed. If any adjustment codes are not listed on the commercial insurance EOB, choose the most appropriate code from the HIPAA related code list.
- Click on “Done”.



State of Missouri Medicaid



Medicare CMS 1500 Part B Crossover

If you are not , please logout

[Logout](#)

User:

Provider:

500000000 SAMPLE NUMBER

Claim Frequency Type Code*		Provider Medicare Number*	
1-Original		F00000XA	
Patient Name (Last Name, First Name)*		Patient Medicaid ID*	
Shriek Will		99999999	
Patient Medicare ID (HIC)*		Patient Account No.	
490000000A		100ws	
Hospitalization Dates (mm/dd/yy)*		Diagnosis Codes* (Do not include the decimal)	
From Date 01 / 05 / 06		1. 46619 2. 3. 4. 5.	
Thru Date 01 / 05 / 06			
Resubmission Ref. No.			

Line No.	From Date of Service (mm/dd/yy)*	Diagnosis Code*	Paid Amount \$*	Detail Line Attachments
	Thru Date of Service (mm/dd/yy)*	Days/Units Billed*		
	Place of Service*	Billed Charges \$*	Medicaid Performing Provider ID*	
	Procedure Code* and Modifiers			
1.	01 / 05 / 06	1	25.88	[Other Payers]
	01 / 05 / 06	1	200000000	
	21-Inpatient			
	99231			

[ADD DETAIL LINES](#)

Claim Attachment Actions:

[\[Add Header Other Payers\]](#) [\[View All Other Payers\]](#)

[Continue...](#)

[Reset](#)

[\[Home\]](#) [\[Help\]](#)

- This brings you back to the original screen. At this point, you are done entering the information. Click on “Continue”.
- This brings you to a screen asking you to verify the information entered.
- You can either edit the information or submit.
- Click on “Submit”. After submitting your claim, you will be brought to a screen which states, “Thank you. Your claim has been received”. Click on the “Print” button at the bottom of the screen to print off and save for your records.
- To enter another claim, click on “Next”.

The end.

FQHC - PART B OF A (NO TPL)

UNITED GOVERNMENT SERVICES, LLC.				401 W. MICHIGAN ST. MILWAUKEE, WI 53203-2804				VER# 4010A1			
260000		MID-MO HEALTH SERVICES		PART B		PAID DATE: 03/01/2006		REMIT #: 95000		PAGE: 1	
PATIENT NAME	PATIENT CNTRL NUMBER	RC	REM	DRG #	DRG OUT AMT	COINSURANCE	PAT REFUND	CONTRACT ADJ			
HIC NUMBER	ICN NUMBER	RC	REM	OUTCD	CAPCD	NEW TECH/ECT	COVD CHGS	ESRD NET ADJ			
FROM DT THRU DT	NACHG HICHG TOB	RC	REM	PROF COMP	MSP PAYMT	NCOVD CHGS	INTEREST	PROC CD AMT			
CLM STATUS	COST COVDY NCOVDY	RC	REM	DRG AMT	DEDUCTIBLES	DENIED CHGS	PRE PAY ADJ	NET REIMB			
SHRIECK, W W 10000B	94 MA01				.00	10.20	.00	31.28-			
400000000A	20603500000000	2			.00	51.00	.00	90.10			
02/01/2006 02/01/2006	731				.00	.00	.00	.00			
19					.00	.00	.00	72.08			

► Using this example of a Medicare EOMB, the following pages will guide you step-bystep through the process to file your Crossover Claim through the Medicaid billing web site at www.emomed.com to collect the co-insurance/deductible amount.

Please turn the page.



State of Missouri Medicaid



Medicare UB92 Part B Crossover

If you are not , please logout

[Logout](#)

User:

Provider:

500000000 SAMPLE NUMBER

Claim Frequency Type Code*		Provider Medicare Number*			
1-Original		260000			
Patient Name (Last Name, First Name)*		Patient Medicaid ID*			
Shriek Will		99999999			
Patient Medicare ID (HIC)*		Patient Account No.			
400000000A		10000B			
Resubmission Ref. No.		Type of Bill*			
		73-Clinic, Free Standing Health Center			
Diagnosis Codes* (Do not include the decimal)		Attending Physician ID*			
1. 5591 2. 7580 3. 4. 5.		200000000			
Surgery Procedure Code		Surgery Procedure Code			
Date (mm/dd/yy)		Date (mm/dd/yy)			
Line No.	Revenue Code	From Date (mm/dd/yy)*	Billed Charges \$*	Procedure Code*	Detail Line Attachments
	Days/Units Billed*	Thru Date (mm/dd/yy)*	Paid Amount \$*	Modifiers	
1.	0		0.00		[Other Payers]
			0.00		

[ADD DETAIL LINES](#)

Claim Attachment Actions:

[\[Add Header Other Payers\]](#) [\[View All Other Payers\]](#)

[Continue...](#)

[Reset](#)

[\[Home\]](#) [\[Help\]](#)

- At the Medicaid billing Web site, click on “Medicare UB92 Part B of A Crossover”. This will bring you to the screen above.
- Enter all the Medicaid header information. Refer to the Medicare EOMB on the previous page as well as the patient’s medical record. Complete the fields as shown above then click on the “Add Header Other Payers” link at the bottom of the page to enter the header other payer information.



State of Missouri Medicaid



Other Payer Header Information

Enter Other Payer(s) Header Information for Medicare UB92 Part B Crossover claim.

Fields marked * must be filled in.

Other Payer #1					
Filing Indicator* MB-Medicare		Other Payer Name* United Govt. Services			
Paid Amount \$ 72.08		Paid Date (mm/dd/yy)* 03 / 01 / 06		Medicare Claim No. 20603500000000	
Header Allowed Amount \$ * 51.00		Total Denied Amount \$ 0.00			
Group Codes, Reason Codes & Adjustment Amounts					
Group Code	Reason Code	Adjust Amount \$	Group Code	Reason Code	Adjust Amount \$
Add Reason Codes					
Remark Codes					
Remove Payer #1					

Add Payer

Done

Cancel

[\[Help\]](#)

- Now you are on the “Other Payer Header” screen.
- Enter the information as shown. For Part B and Part B of A crossover claims, you do not enter the Group Codes, Reason Codes and Adjustment Amounts information. You will be entering this information elsewhere.
- Click on “Done”.



State of Missouri Medicaid



Medicare UB92 Part B Crossover

If you are not [here](#), please logout

[Logout](#)

User:

Provider: 500000000 SAMPLE NUMBER

Claim Frequency Type Code*		Provider Medicare Number*			
1-Original		260000			
Patient Name (Last Name, First Name)*		Patient Medicaid ID*			
Shriek Will		99999999			
Patient Medicare ID (HIC)*		Patient Account No.			
400000000A		10000B			
Resubmission Ref. No.		Type of Bill*			
		73-Clinic, Free Standing Health Center			
Diagnosis Codes* (Do not include the decimal)		Attending Physician ID*			
1. 5591 2. 7580 3. 4. 5.		200000000			
Surgery Procedure Code		Surgery Procedure Code			
Date (mm/dd/yy)		Date (mm/dd/yy)			
Line No.	Revenue Code	From Date (mm/dd/yy)*	Billed Charges \$*	Procedure Code*	Detail Line Attachments
	Days/Units Billed*	Thru Date (mm/dd/yy)*	Paid Amount \$*	Modifiers	
1.	0520	02 / 01 / 06	51.00	00000	[Other Payers]
	1	02 / 01 / 06	72.08		

[ADD DETAIL LINES](#)

Claim Attachment Actions:

[\[Add Header Other Payers\]](#) [\[View All Other Payers\]](#)

[Continue...](#)

[Reset](#)

[\[Home\]](#) [\[Help\]](#)

- Now you are back on the original screen ready to add your detail information to the claim.
- Again, using the Medicare EOMB example from the first page, enter the detail information as shown above. If you did not report a procedure code to Medicare, enter "00000" in the Procedure Code Field.
- When done entering the information, click on "Other Payers" to add the Medicare detail information.



State of Missouri Medicaid



Other Payer Detail Information

Enter Other Payer(s) Detail Information for Medicare UB92 Part B Crossover claim.
Fields marked * must be filled in.

Claim Detail Line #1					
Other Payer #1					
Paid Date (mm/dd/yy)*		03 / 01 / 06			
Group Codes, Reason Codes & Adjustment Amounts					
Group Code	Reason Code	Adjust Amount \$	Group Code	Reason Code	Adjust Amount \$
PR-Patient Responsibility	002	10.20	CO-Contractual Obligation	094	0.00
					Add Reason Codes
					Remove Payer #1
Add Payer					
Done Cancel					

[\[Help\]](#)

- Now you are on the “Other Payer Detail” screen.
- Enter the Medicare paid date information as well as the Group and Reason Codes and Adjustment Amounts. See the above sample. If the reason codes are not listed on your Medicare EOMB, choose the most appropriate code from the list of “Claim Adjustment Reason Codes” from the HIPAA Related Code List. For example, the code on the Claim Adjustment Reason Code list for deductible amount is 1 and for coinsurance amount is 2. Therefore, you would enter a Reason Code of 001 for deductible amounts and 002 for coinsurance amounts due.
- The “Adjust Amount” should reflect any amount not paid by Medicare including deductible, coinsurance and any non-allowed amounts.
- Medicare may report a negative “Contractual Adjustment” amount on the Medicare EOMB. When this occurs, enter the appropriate group and reason codes with a “zero” adjustment amount.
- Click on “Done”.



State of Missouri Medicaid



Medicare UB92 Part B Crossover

If you are not , please logout

User: Provider:

Claim Frequency Type Code*		Provider Medicare Number*	
<input type="text" value="1-Original"/>		<input type="text" value="260000"/>	
Patient Name (Last Name, First Name)*		Patient Medicaid ID*	
<input type="text" value="Shriek"/> <input type="text" value="Will"/>		<input type="text" value="99999999"/>	
Patient Medicare ID (HIC)*		Patient Account No.	
<input type="text" value="400000000A"/>		<input type="text" value="10000B"/>	
Resubmission Ref. No.		Type of Bill*	
<input type="text"/>		<input type="text" value="73-Clinic, Free Standing Health Center"/>	
Diagnosis Codes* (Do not include the decimal)		Attending Physician ID*	
1. <input type="text" value="5591"/> 2. <input type="text" value="7580"/> 3. <input type="text"/> 4. <input type="text"/> 5. <input type="text"/>		<input type="text" value="200000000"/>	
Surgery Procedure Code		Surgery Procedure Code	
<input type="text"/>		<input type="text"/>	
Date (mm/dd/yy)		Date (mm/dd/yy)	
<input type="text"/> / <input type="text"/> / <input type="text"/>		<input type="text"/> / <input type="text"/> / <input type="text"/>	
<input type="text"/>		<input type="text"/>	
Date (mm/dd/yy)		Date (mm/dd/yy)	
<input type="text"/> / <input type="text"/> / <input type="text"/>		<input type="text"/> / <input type="text"/> / <input type="text"/>	
<input type="text"/>		<input type="text"/>	
Date (mm/dd/yy)		Date (mm/dd/yy)	
<input type="text"/> / <input type="text"/> / <input type="text"/>		<input type="text"/> / <input type="text"/> / <input type="text"/>	
<input type="text"/>		<input type="text"/>	

Line No.	Revenue Code	From Date (mm/dd/yy)*	Billed Charges \$*	Procedure Code*	Detail Line Attachments
	Days/Units Billed*	Thru Date (mm/dd/yy)*	Paid Amount \$*	Modifiers	
1.	<input type="text" value="0520"/>	<input type="text" value="02"/> / <input type="text" value="01"/> / <input type="text" value="06"/>	<input type="text" value="51.00"/>	<input type="text" value="00000"/>	[Other Payers]
	<input type="text" value="1"/>	<input type="text" value="02"/> / <input type="text" value="01"/> / <input type="text" value="06"/>	<input type="text" value="72.08"/>	<input type="text"/>	

Claim Attachment Actions:
[\[Add Header Other Payers\]](#) [\[View All Other Payers\]](#)

[\[Home\]](#) [\[Help\]](#)

- This brings you back to the original screen. At this point, you are done entering the information. Click on "Continue".
- This brings you to a screen asking you to verify the information entered. You can either edit the information or submit.
- Click on "Submit".
- After submitting your claim, you will be brought to a screen which states, "Thank you. Your claim has been received". Click on the "Print" button at the bottom of the screen to print off and save for your records.
- To enter another claim, click on "Next".

THE END

SAMPLE - MEDICARE REMITTANCE

PART B OF A - DIALYSIS CLINIC

Medicare National Standard Intermediary Remittance Advice

26XXXX									
TRANSFER TO (COB): MISSOURI MEDICAID									
PATIENT: SHRIEK									
HIC: 400000000T									
PAT STAT: CLAIM STAT: 19									
CHARGES:									
27937.50=REPORTED									
0.00=NCVD/DENIED									
0.00=CLAIM ADJS.									
4415.79=COVERED									
DAYS/VISITS:									
0=COST REPT									
0=COVD/UTIL									
0=NON-COVERED									
0=COVD VISITS									
0=NCOV VISITS									
REMARK CODES:									
MA01									
REV	DATE	HCPCS	APC/HIPPS MODS	QTY	CHARGES	ALLOW/REIM	GC	RSN	AMOUNT
0270	01/02	A4657		12	627.12	4.80	CO	42	621.12
							PR	2	1.20
0635	01/02	Q4055		12	13461.48	974.44	CO	45	12243.43
							PR	2	243.61
0821	01/02	90999		13	13848.90	2050.00	CO	118	6.50
								45	11278.28
							PR	2	514.12

- Using this example of a Medicare EOMB, the following pages will guide you step-by-step through the process to file your crossover claim through the Medicaid billing Web site at www.emomed.com to collect the deductible/coinsurance amount.



State of Missouri Medicaid



Medicare UB92 Part B Crossover

If you are not , please logout

Logout

User:

Provider:

500000000 SAMPLE NUMBER

Claim Frequency Type Code*		Provider Medicare Number*			
1-Original		26xxxx			
Patient Name (Last Name, First Name)*		Patient Medicaid ID*			
Shriek Will		99999999			
Patient Medicare ID (HIC)*		Patient Account No.			
400000000T					
Resubmission Ref. No.		Type of Bill*			
		72-Clinic, Renal Dilaiysis			
Diagnosis Codes* (Do not include the decimal)		Attending Physician ID*			
1. 585 2. 2809 3. 28521 4. 5.		200000000			
Surgery Procedure Code		Surgery Procedure Code			
Date (mm/dd/yy)		Date (mm/dd/yy)			
Line No.	Revenue Code	From Date (mm/dd/yy)*	Billed Charges \$*	Procedure Code*	Detail Line Attachments
	Days/Units Billed*	Thru Date (mm/dd/yy)*	Paid Amount \$*	Modifiers	
1.	0	/ /	0.00		[Other Payers]
		/ /	0.00		

ADD DETAIL LINES

Claim Attachment Actions:

[\[Add Header Other Payers\]](#) [\[View All Other Payers\]](#)

[Continue...](#)

[Reset](#)

[\[Home\]](#) [\[Help\]](#)

- **At** the Medicaid billing Web site, click on “Medicare UB92 Part B of A Crossover”. This brings you to the screen above.
- **Enter all the Medicaid header information.** Refer to the Medicare EOMB on the previous page as well as the patient’s medical record. Complete the fields as shown above. Then click on the “Add Header Other Payers” link at the bottom of the page to enter the header other payer information.



State of Missouri Medicaid



Other Payer Header Information

Enter Other Payer(s) Header Information for Medicare UB92 Part B Crossover claim.

Fields marked * must be filled in.

Other Payer #1					
Filing Indicator*	MB-Medicare		Other Payer Name*	Riverbend	
Paid Amount \$	3029.24		Paid Date (mm/dd/yy)*	03 / 01 / 06	
			Medicare Claim No.	20603800000000	
Header Allowed Amount \$ *	4415.79		Total Denied Amount \$	0.00	
Group Codes, Reason Codes & Adjustment Amounts					
Group Code	Reason Code	Adjust Amount \$	Group Code	Reason Code	Adjust Amount \$
					Add Reason Codes
Remark Codes					
					Remove Payer #1

[\[Help\]](#)

- Now you are on the "Other Payer Header" screen.
- Enter the information as shown. For Part B and Part B of A crossover claims, do not complete the Group Codes, Reason Codes and Adjustment Amounts information. You will enter this information elsewhere.
- Click on "Done".



State of Missouri Medicaid



Medicare UB92 Part B Crossover

If you are not , please logout

[Logout](#)

User:

Provider:

500000000 SAMPLE NUMBER

Claim Frequency Type Code*		Provider Medicare Number*			
1-Original		26xxxx			
Patient Name (Last Name, First Name)*		Patient Medicaid ID*			
Shriek Will		99999999			
Patient Medicare ID (HIC)*		Patient Account No.			
400000000T					
Resubmission Ref. No.		Type of Bill*			
		72-Clinic, Renal Dilayysis			
Diagnosis Codes* (Do not include the decimal)		Attending Physician ID*			
1. 585 2. 2809 3. 28521 4. 5.		200000000			
Surgery Procedure Code		Surgery Procedure Code			
Date (mm/dd/yy)		Date (mm/dd/yy)			
Line No.	Revenue Code	From Date (mm/dd/yy)*	Billed Charges \$*	Procedure Code*	Detail Line Attachments
	Days/Units Billed*	Thru Date (mm/dd/yy)*	Paid Amount \$*	Modifiers	
1.	0270	01 / 02 / 06	627.12	A4657	[Other Payers]
	12	01 / 02 / 06	4.80		

[ADD DETAIL LINES](#)

Claim Attachment Actions:

[\[Add Header Other Payers\]](#) [\[View All Other Payers\]](#)

[Continue...](#)

[Reset](#)

[\[Home\]](#) [\[Help\]](#)

- You are now back to the original screen ready to add your detail information to the claim.
- Again using the Medicare EOMB example from the first page, enter the detail information shown above for line one. If you did not report a procedure code to Medicare, enter "00000" in the Procedure Code field.
- When done entering the information, click on "Other Payers" to add the Medicare detail information.



State of Missouri Medicaid



Other Payer Detail Information

Enter Other Payer(s) Detail Information for Medicare UB92 Part B Crossover claim.

Fields marked * must be filled in.

Claim Detail Line #1
Other Payer #1

Paid Date (mm/dd/yy)* / /

Group Codes, Reason Codes & Adjustment Amounts					
Group Code	Reason Code	Adjust Amount \$	Group Code	Reason Code	Adjust Amount \$
CO-Contractual Obligation	042	621.12	PR-Patient Responsibility	002	1.20

[Add Reason Codes](#)

[Remove Payer #1](#)

[Add Payer](#)

[Done](#) [Cancel](#)

[\[Help\]](#)

- Now you are on the "Other Payer Detail" Screen. Scroll to the bottom of the form and click on the "Help" button, print off and save the instructions.
- Scroll back to the top, complete the Medicare paid date information as well as the Group and Reason Codes and Adjustment Amounts. See above sample. If the reason codes are not listed on your Medicare EOMB, choose the most appropriate code from the list of "Claim Adjustment Reason Codes" from the HIPAA Related Code List. For example, the code on the "Claim Adjustment Reason Code" list for deductible amount is 1 and for coinsurance amount is 2. Therefore, you would enter a Reason Code of 001 for deductible amounts and 002 for coinsurance amounts due.
- The "Adjust Amount" should reflect any amount not paid by Medicare including deductible, coinsurance and any non-allowed amounts.
- Click on "Done".



State of Missouri Medicaid



Other Payer Detail Information

Enter Other Payer(s) Detail Information for Medicare UB92 Part B Crossover claim.

Fields marked * must be filled in.

Claim Detail Line #2
Other Payer #1

Paid Date (mm/dd/yy)* / /

Group Codes, Reason Codes & Adjustment Amounts					
Group Code	Reason Code	Adjust Amount \$	Group Code	Reason Code	Adjust Amount \$
CO-Contractual Obligation	045	12243.43	PR-Patient Responsibility	002	243.61

[Add Reason Codes](#)

[Remove Payer #1](#)

[Add Payer](#)

[Done](#) [Cancel](#)

[\[Help\]](#)

- Enter a claim detail line and “Other Payer Detail” for each line from your Medicare EOMB.
- This is a sample detail entry for line 2 showing both contractual and patient responsibility codes and amounts.
- After all claim detail lines have been entered, click “Done”.



State of Missouri Medicaid



Other Payer Detail Information

Enter Other Payer(s) Detail Information for Medicare UB92 Part B Crossover claim.

Fields marked * must be filled in.

Claim Detail Line #3

Other Payer #1

Paid Date (mm/dd/yy)* / /

Group Codes, Reason Codes & Adjustment Amounts					
Group Code	Reason Code	Adjust Amount \$	Group Code	Reason Code	Adjust Amount \$
CO-Contractual Obligation	118	6.50	CO-Contractual Obligation	045	11278.28
PR-Patient Responsibility	002	514.12			

[Add Reason Codes](#)

[Remove Payer #1](#)

[Add Payer](#)

[Done](#) [Cancel](#)

[\[Help\]](#)

- Enter a claim detail line and “Other Payer Detail” for each line from your Medicare EOMB.
- This is a sample detail entry for line 3 showing both contractual and patient responsibility codes and amounts.
- After all claim detail lines have been entered, click “Done”.



State of Missouri Medicaid



Medicare UB92 Part B Crossover

If you are not , please logout

Logout

User:

Provider:

500000000 SAMPLE NUMBER

Claim Frequency Type Code*		Provider Medicare Number*			
1-Original		26xxxx			
Patient Name (Last Name, First Name)*		Patient Medicaid ID*			
Shriek Will		99999999			
Patient Medicare ID (HIC)*		Patient Account No.			
400000000T					
Resubmission Ref. No.		Type of Bill*			
		72-Clinic, Renal Dilaiysis			
Diagnosis Codes* (Do not include the decimal)		Attending Physician ID*			
1. 585 2. 2809 3. 28521 4. 5.		200000000			
Surgery Procedure Code		Surgery Procedure Code			
Date (mm/dd/yy)		Date (mm/dd/yy)			
Line No.	Revenue Code	From Date (mm/dd/yy)*	Billed Charges \$*	Procedure Code*	Detail Line Attachments
	Days/Units Billed*	Thru Date (mm/dd/yy)*	Paid Amount \$*	Modifiers	
1.	0270	01 / 02 / 06	627.12	A4657	[Other Payers]
	12	01 / 02 / 06	4.80		
2.	0635	01 / 02 / 06	13461.48	Q4055	[Other Payers]
	12	01 / 02 / 06	974.44		
3.	0821	01 / 02 / 06	13848.90	90999	[Other Payers]
	13	01 / 02 / 06	2050.00		
ADD DETAIL LINES					

Claim Attachment Actions:

[Add Header Other Payers] [View All Other Payers]

Continue...

Reset

[Home] [Help]

- When you click “Done” on the last line detail entry screen, you will be brought back to the original screen which should show the basic information for each detail line.
- Since you are now done entering the header and detail information, click on “Continue”.
- This brings you to a screen asking you to verify the information entered.

(continued on the next page)

- You can either edit the information or submit. Click on 'Submit'.
- After submitting your claim, you will be brought to a screen which states, "Thank you. Your claim has been received". Click on the "Print" button at the bottom of the screen to print off this page and save for your records.
- To enter another claim, click on "Next".

THE END